C. Needs Assessment Summary

Wisconsin's 10 Priority Needs

In selecting the 10 Priority Needs, we considered the new emerging priority needs the LPHD directors identified, as well as the availability of data, and areas already addressed by the National and State Performance Measures and Health Status Indicators.

1. Dental Access and Care: To assure dental health for children.
2. Health Access: To assure quality standards, care coordination, and access to health care.
3. Child Care: To assure safe and healthy child care.
4. Family and Parenting: To increase parenting skills.
5. CSHCN Systems of Care: To assure a community-based system of care for CSHCN.
6. Health Disparities: To assure culturally competent services for minority and immigrants.
7. Teen Pregnancy: To increase teenage pregnancy prevention efforts.
8. Alcohol, Tobacco and Other Drugs Use and Abuse: To decrease ATODA among women and children.
9. Early Prenatal Care: To increase early prenatal care especially among minorities.
10. Injury: To decrease unintentional and intentional injuries.

Dental Access and Care – To assure dental health for children

The Children's Health Alliance of Wisconsin (CHAW) has been actively involved in improving dental access and care. Additional Family Health Section program efforts are underway to hire a Public Health Educator as a dental health consultant trained as a dental hygienist with experience in public health. Once the dental health consultant is hired, the incumbent will oversee oral health surveillance, to determine the baseline for children 6-8 years with untreated dental decay and participate in clinical screening assessments. A new state performance measure, "Percent of children, ages 6-8, with untreated dental decay in primary and permanent teeth" was created to address the concerns for dental access and care voiced around the state.

/2003/ The MCH Oral Health Consultant was hired and conducted the *Make Your Smile Count Survey* of third grade children, releasing data in 2001 and 2002. Along with the 2001-02 the *Make Your Smile Count* survey, secondary data (e.g., from Medicaid and Health Professional Shortage Areas) more fully assesses the oral health status of Wisconsin children. The *Make Your Smile Count* survey and the secondary data collection is a portion of a grant funded by the Centers for Disease Control. //2003//

/2004/ A forum to release the data collection reports was conducted in December of 2002. In addition, a survey of Head Start children is planned for spring 2003. //2004//

/2005/ *A survey of children enrolled in HeadStart was conducted in 2003 and released at a HeadStart Forum. Five regional oral health consultants were contracted to provide technical assistance and training. Technical assistance was provided to LPHDs, Federally Qualified Health Centers and tribes regarding maternal oral health and early childhood caries prevention.* ***//2005//***

Health Access – To assure quality standards, care coordination, and access to health care

/2004/ This remains a need for various populations in Wisconsin as is evidenced by the increase in enrollment in

Wisconsin's Family Medicaid and BadgerCare. "Access to primary and preventive health services" is also one of the 11 Health Priorities for Healthiest Wisconsin 2010. //2004//

/2005/ *No significant change.* ***//2005//***

Child Care – To assure safe and healthy child care

At this time, as state performance measure has not been identified for this priority need.

/2003/ Significant efforts were made to establish partnerships with the child care community and to raise awareness of the need to address health issues in child care. //2003//

/2004/ Health issues in child care remain a priority and will be more fully addressed through our Early Childhood Comprehensive Systems (ECCS) Grant. //2004//

/2005/ *The ECCS coordinator was hired several months into the planning grant and has re-established contacts with the early care and education community. Key partners in these components, as well as leaders in the two Wisconsin Healthy Child Care America (HCCA) grant areas, are closely involved in ECCS planning process. ECCS is committed to building on the HCCA grants - supporting and enhancing health consultation in child care settings - as the HCCA federal funding is winding down. Wisconsin's ECCS is assuming leadership in comprehensive early childhood systems development statewide with a special focus in the City of Milwaukee. Component partners are actively engaged in planning activities from: medical home and health care access, infant mental health and social emotional development, early care and education (child care, headstart, 4-K etc), parent education, and family support.* ***//2005//***

Family and Parenting – To increase parenting skills

Family Violence – Directors suggested adding a performance measure for family violence. Although we did not develop an SPM for family violence, we concluded that efforts to increase MCH clients who receive parenting skills and training would encompass information on family violence, including education on intentional and unintentional injury prevention.

/2003/ We decided that a SPM should capture the services provided by LPHDs regarding parenting and safety. Therefore, we dropped SPM #9 and replaced it with SPM #16 which reads the percent of MCH clients/families who receive one or more supportive services to enhance child health, child development and/or safety. //2003//

/2004/ No significant change, although, again, this will become more of a focus for our ECCS grant. //2004//

/2005/ *Governor Doyle supports a "comprehensive effort of parent education and support" to provide parent education services to every new family in the state. The ECCS grant is funding development of core competencies for parent educators and home visitors in the state to improve effectiveness of parent education program services.* ***//2005//***

Family and Parenting – To increase parenting skills

The importance of nutrition for children begins with the family. Good eating habits start early and are dependent on what parents promote.

Comprehensive Nutrition Approach – Directors felt that a more comprehensive nutrition approach should be adopted. Therefore, the state performance measure dealing with percent of high school youth who self-report eating fruits and vegetables during the previous day was eliminated.

/2003/ SPM #11 focused on obesity for children 6-17 years of age. After a year we revised the measure, now SPM #13, to reflect children ages 2-4 years as a predictor of future obesity. Since weight and height data are collected by the WIC program and sent to CDC for analysis by the Pediatric Nutrition Surveillance System (PedNSS) standardized reports for children 2-4 years are produced for overweight and high weight-for-height (>95th percentile wt/ht). //2003//

/2004/ No significant change. //2004//

/2005/ *In 2004, SPM #13 is focused on overweight in children aged 2-4 as a predictor of future overweight and obesity. Height and weight data for this age group is available through the CDC PedNSS. Although this represents a higher risk population of WIC Program participants it does gives an indication of the percentage of children who are overweight as well as those who are at risk of overweight. The issue of overweight, obesity and lack of physical activity has become a priority in Wisconsin. Title V will work closely with the Wisconsin Nutrition and Physical Activity Workgroup (WINPAW), the CDC Nutrition and Physical Activity (N&PA) grant, the Wisconsin Action for Healthy Kids Coalition, and the Comprehensive School Health Program (CSHP) to address this issue. A Nutrition and Physical Activity Plan for Wisconsin will be developed by December 2004 that will outline strategies based on the socio-ecological model.* ***//2005//***

<u>CSHCN Systems of Care – To assure a community-based system of care for CSHCN</u>

Although a specific state performance measure was not created to match with this emerging need, it was exciting to have the directors identify systems of care for CSHCN as a priority. For now, it was decided that the six national performance measures adequately address the systems concern. The Family Health Section program efforts to develop CSHCN services at the local level are underway with the establishment of the five Regional CSHCN Centers and the required partnership between the centers and LPHDs.

/2004/ Systems of care for children with special health care needs relates to national performance measures #2, #3, and #4. When looking at the different systems of care that children encounter, they interact with the medical system and the community-based service system; insurance coverage affects a family's utilization of services within both systems. The Title V MCH/CSHCN Program in Wisconsin is working to address each of these performance measures in turn, as referenced in the National Performance Measures Section. In terms of capacity and resource capability to address systems of care for CSHCN, Wisconsin Title V is working with pediatric and community partners to affect systems level change statewide through such efforts as a medical home learning collaborative, outreach and social marketing strategies, and health education and training. //2004//

/2005/ *With the reorganization of the Bureau of Family and Community Health (BFCH) to the Bureau of Community Health Promotion (BCHP), it is hoped that stronger linkages will be formed with the integration of CSHCN into other community-based service systems of care (i.e., N&PA, Injury Prevention, Tobacco Prevention) so children with special health care needs and their families can better access these services.* ***//2005//***

Health Disparities – To assure culturally competent services for minorities and immigrants

The FHS will work on increasing LPHDs capacity in providing family centered, culturally competent services through regional education and training efforts. As part of the consolidated contract process, LPHDs are asked to complete the MCH Guiding Principles Organization Self-Assessment Tool annually to determine their progress on providing family centered, culturally competent care and to develop a plan to improve their progress.

/2003/ Due to the significant gap in Wisconsin between the IMR of African American and white infants, SPM #14 was created which reads the ratio of black infant mortality rate to the white infant mortality rate. This SPM replaces the percent of infants born with low birth weight among all racial ethnic or age groups (SPM #8). //2003//

/2004/ The issue of health disparities in Wisconsin is receiving increased attention. Title V will be working in concert with the Minority Health Officer in our on-going assessment of need. "Social and economic factors that influence health" is one of the 11 Health Priorities for Healthiest Wisconsin 2010. //2004//

/2005/ *An internal department workgroup, was formed. It was lead by MCH Program staff with the assistance of Department staff assigned to address the issue of disparities in health. The workgroup: the Racial and Ethnic Disparities in Birth Outcomes Action Team, (REDBOAT) met to plan a follow-up meeting in May 2004 to the 2003 Healthy Babies Summit. The initial focus is on African American infant deaths in southern and southeastern Wisconsin. In follow-up to the May 10th meeting, the DHFS Secretary requested that a task force of department staff and community partners make recommendations to her for a strategic action plan in Milwaukee, including a combined approach between Medicaid and Public Health. In addition, efforts on reducing disparities in birth outcomes will be linked to the Governor's recently released "KidsFirst" plan. See website at* ***http://www.wisgov.state.wi.us/docs/kidsfirst.pdf****. Community organizations and the DHFS plan to apply for BC/BS asset conversion funds, which have been designated for public health purposes. Proposals will include both a statewide and a targeted approach to addressing racial and ethnic disparities in birth outcomes.* ***//2005//***

Health Disparities – for Children with Developmental Disabilities

/2004/ Research indicates that individuals with developmental disabilities are compared to the general population have four times more preventable mortality, less access to primary and specialty health care providers, and higher rates of obesity, asthma, otitis media, cardiovascular disease, depression, and other mental health conditions. In December 2001 Surgeon General David Satcher, MD, PhD convened a national conference on Health Disparities and Mental Retardation. In preparation for the conference a national Listening Session was held with the Waisman Center at the University of Wisconsin serving as one of four national session sites. In an effort to build on the national momentum and to continue discussions in Wisconsin, an invitational conference was held in October 2002 where recommendations and next steps were developed. These recommendations were developed as "A Wisconsin Blueprint to Improve the Health of Individuals with Developmental Disabilities" available at **www.waisman.wisc.edu/healthdisparities/index.html**. A follow-up meeting in May 2003 provided an opportunity for workgroups to report on their implementation progress. //2004//

/2005/ *These workgroups have continued and now focus on the following three areas: Organization and Financing, Training of Healthcare Providers, and Information, Assistance, and Advocacy (IAA). The Organization and Financing Workgroup has created a report that includes the concepts of care and access for the individual, regional*

*coordination, training for consumers and providers and individual/system outcomes. This report includes many of the concepts of Medical Home within the provision of care. The IAA Workgroup has convened a series of meetings to bring together agencies providing referral, follow up, advocacy services throughout the state for individuals with disabilities and special health care needs. An inventory of these agencies and their services has been developed. These agencies have also identified ways to collaborate such as: promotion of a common resource database, shared trainings, website links. This "network" of providers will next explore ways to collect data related to unmet needs. Health Disparities for children and youth with special health care needs and individuals with developmental disabilities is now included in the Department's strategic plan. //**2005**//*

Teen Pregnancy – To increase teenage pregnancy prevention efforts

/2004/ In Wisconsin's spring of 2000 needs and strengths assessment, teen pregnancy was identified as one of the most significant family needs from the LPHD and from the tribal health center perspective. Even though Wisconsin's 2001 teen birth rate for ages 15-19 (34.2 births per 1,000 females) was about two-thirds the national rate (45.9 per 1,000) **http://www.dhfs.state.wi.us/wish/main/Teen_preg/teen_preg_data_2001.htm** many agencies determine this an ongoing need and continue to focus their efforts on teen pregnancy prevention. Of note, rates for ages 15-19 in Wisconsin are based on these age-specific populations, plus 80 births to mothers less than 15 years old. National data for 2001 (preliminary) does not include births to mothers less than 15 years old. //2004//

*/**2005**/ The Adolescent Pregnancy Prevention Committee (APPC) has developed 2010 goals as well as strategies for implementing our adolescent pregnancy prevention plan. Seven subcommittees working to achieve these goals are Networking; Resources Online; Training, Curriculum, and Education; Awareness; Community Response Teams; APPC Oversight; and Health Care. Wisconsin Abstinence Initiative for Youth (WAIY) has goals and strategies to increase delivery of abstinence education to Wisconsin's youth. The Family Planning Waiver, started January 2003, provides reproductive health care to women aged 15-44. Along with the Family Planning providers, a number of LPHDs use their MCH funds to provide health care services and education to prevent teen pregnancies. //**2005**//*

ATODA Use and Abuse – To decrease ATODA among women and children

After reviewing other state's performance measures regarding adolescent and youth, we considered removing SPM #4 (Percent of high school youth who self report taking a drink in the past 30 days) and SPM #5 (Percent of high school youth who self report tobacco use e.g., cigarettes, chewing tobacco, etc. over the past 30 days).

/2003/ However, based on internal discussions we decided to maintain SPM #4 which addresses youth drinking. We eliminated SPM #5 because efforts addressing tobacco use among youth were concentrated in another bureau within the DPH. //2003//

/2004/ Wisconsin remains a state with high smoking and binge drinking rates. Significant collaborative efforts have been made with the Wisconsin Women's Health Foundation on their "First Breath" Project to reduce smoking among pregnant women**.** First Breath was mentioned in a letter from Rep. Waxman addressed to The Honorable Tommy G. Thompson, Secretary of the Department of Health and Human Services (DHHS), "I am aware of your and your wife's personal interest in smoking cessation. The Wisconsin Women's Health Foundation, which your wife founded, sponsors an innovative pilot program called First Breath. This initiative provides pregnant women

with smoking cessation services....across Wisconsin. Such resources are exactly what all of the tobacco-addicted parents and pregnant women in our country deserve." //2004//

/2005/ *Reduction of tobacco use efforts continue through Wisconsin's Tobacco Prevention and Control Program, First Breath Prenatal Smoking Cessation Program and MCH-funded perinatal care coordination. The State Council on Alcohol and Other Drug Abuse coordinates and reviews the abuse control and prevention efforts of state agencies through evaluation of program effectiveness, improvement recommendations, and reports educating about the dangers of alcohol and drug use and abuse.* ***//2005//***

Early Prenatal Care – To increase early prenatal care especially among minorities

/2003/ First trimester prenatal care data reveal the following statewide statistics for women from the following population groups: White-87.7%; Black-69.7%; American Indian-72.0%; Hispanic-68.4%; and Laotian/Hmong-47.2%. //2003//

/2004/ In state fiscal year 2002, of those women receiving Perinatal Care Coordination services, 77.6% received first trimester prenatal care. For the two federal Healthy Start Projects in 2002, the percent of women receiving first trimester prenatal care include: HOC Project, serving American Indian women; 80.0% and Milwaukee Healthy Beginnings Project, serving African American women: 74.5%. //2004//

/2005/ *The overall proportion of women in Wisconsin who received first-trimester prenatal care was 84% in 2002, compared with 82% in 1992. The proportion with first-trimester care increased among each age group and each race/ethnicity group.*

For women receiving MCH funded services and represented in SPHERE, 80% (373/466) began prenatal care in the first trimester. For the Healthy Start project in Milwaukee, 82.4% (211/256) received first trimester prenatal care. Data is not available from the Healthy Start Project with GLITC because of the late start-up of SPHERE. ***//2005//***

Injury Prevention – To decrease unintentional and intentional injuries

/2003/ We created SPM #15 to address what is the major cause of deaths among Wisconsin's youth (Rate of motor vehicle deaths among teenagers ages 15-19). This replaced SPM #9. //2003//

/2004/ Special access issues exist for those living in isolated, rural communities, migrant and seasonal workers, low-income members of racial, ethnic or cultural minority groups, persons with special health care needs, the uninsured, the underinsured and homeless persons (Lewin & Altman, 2000). Injury is a threat to us all. In 2000, unintentional injury, such as falls, burns, motor vehicle crashes, poisonings, and drowning, was the leading cause of death in Wisconsin for ages one to 24 years (National Center for Injury Prevention and Control, CDC, 2000). This measure was chosen to determine impact of local supportive services and programs funded by the MCH Block grant on health, development and safety practices of the families in the state and their children, including children with special health care needs.

Please refer to the Public Input Section of this application regarding recent input received for the MCH Block Grant Application. These suggestions will be given serious consideration as we begin our 2005 MCH Block Grant Needs Assessment. In addition, we will evaluate the recommendations of the Maternal and Child Health Policy and Tobacco Report from the Minority Staff Report, Special Investigations Division, dated February 27, 2003. //2004//

*/**2005**/ Significant MCH funded LPHD activities are in the areas of passenger safety, bike safety, and home safety assessments. The state MCH program is providing leadership in locating funds to build a hand-held computer system, personal data assistant, (PDA), under the leadership of a consortium of agencies in Wisconsin. The system will initially collect data elements for injury prevention service components of home visiting programs. //**2005**//*

D. Health Status Indicators – See Forms 20 and 21

E. Outcome Measures – Federal and State

/2004/ As Wisconsin reviews the results of Outcome Measures #1-#5, we note the major disparity in African American infant mortality and percent low birth weight births as compared with those for non-Hispanic whites in Wisconsin. The efforts we have undertaken for NPMs #15, #17, #18 and SPM #8 are meant to address these findings.

To more effectively address black-white health disparities in Wisconsin, we work closely with the Black Health Coalition in Milwaukee, one of the recipients of a federal Healthy Start grant, "Healthy Beginnings". We are also working closely with the Milwaukee City Health Department which has, as a major focus, prevention of infant mortality and low birth weight among African-Americans in Milwaukee. We participate with both agencies in the Milwaukee FIMR Project. We have been working with our state Medicaid program on the expansion and improvement of prenatal care services to Medicaid recipients and are actively engaged in promoting Wisconsin's supplemental prenatal care benefit, "Prenatal Care Coordination", in WIC clinics throughout Wisconsin.

As is discussed in Sections III and IV, on July 15, 2003, we will be holding a "Perinatal Summit: Healthy Babies in Wisconsin: A Call to Action," where our Secretary of DHFS will be giving a charge to state, regional and community health care professionals, providers, parents, and consumers throughout Wisconsin to focus on removing disparities in perinatal health care. Our national speakers will focus on the use of the Perinatal Periods of Risks model* and on intergenerational risk factors and commulative stress, as new concepts contributing to disparities in health status among the MCH population.

This model identifies needs related to Maternal Health/Prematurity, Maternal Care, Newborn Care, and Infant Health. Each area is associated with specific interventions. Babies born less than 1,500 grams who die during the fetal, neonatal or postneonatal period fall into the category of Maternal Health/Prematurity. High numbers in this category identifies needs for preconception health, positive health behaviors (smoking, drinking, drug use, nutrition), and prenatal care. The Maternal category includes data on fetal deaths with weights of 1,500+ grams. Interventions include Prenatal Care, referral systems, and high-risk obstetric care. The model suggests we can impact the number of infants at 1,500+ grams that die during the newborn period by focusing on perinatal management, perinatal systems, and pediatric surgery. Support and education on sleep position, breast feeding, and injury prevention can impact the number of infants born at 1,500+ grams that die within 28-365 days after birth.

With regard to federal Outcome Measure #6, Child Mortality, ages 1-14 years, unintentional injury is the major cause of death. Activities conducted in Wisconsin are discussed under NPM #8 and SPM #10. The Wisconsin Safe Kids coalitions are expanding throughout the state and Wisconsin has several NHTSA safe communities grants. Many of our projects funded through MCH block grant focus on promotion of child safety seat usage, bicycle helmet usage, and home hazard reduction.

The following table summarizes Wisconsin's Ten Priority Needs, SPMs and National Outcome Measures as requested in past MCH Services Title V Block Grant Program Guidance.

The new guidance requests an additional analysis to include a discussion on the relationship between State program activities, the National and State Performance Measures and the Outcome Measures. Detailed discussions that address this request are found in other sections of the application, including relevant program activity changes that have or will occur. We will include this analysis in the Needs Assessment in the 2006 Title V MCH Block Grant Application. //2004//

/2005/ *As mentioned elsewhere in this application, the Perinatal Summit, "Healthy Babies in Wisconsin: A Call to Action" was held in July 2003. We will continue our active follow up. The balance of the information above provided in 2004 is current.* ***//2005//***